

Appendix 29

Sample CMS 1500 Claim Form: One Trip with Extended Travel (Over 40 miles)

This claim form illustrates a sample form for the example in Appendix 28 of this handbook.

HEALTH INSURANCE CLAIM FORM										PICA
<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> MEDICARE (Medicare #) A </div> <div> <input type="checkbox"/> MEDICAID (Medicaid #) </div> <div> <input type="checkbox"/> CHAMPUS (Sponsor's SSN) </div> <div> <input type="checkbox"/> CHAMPVA (VA File #) </div> <div> <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) </div> <div> <input type="checkbox"/> FECA BLK LUNG (SSN) </div> <div> <input type="checkbox"/> OTHER (ID) </div> </div> <div> 1a. INSURED'S I.D. NUMBER 1234567890 </div> </div>										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.				3. PATIENT'S BIRTH DATE MM DD YY MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) 609 Willow				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				
CITY Anytown		STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE		
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-D				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____										
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring				17a. I.D. NUMBER OF REFERRING PHYSICIAN A12345		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. T005 2. V63.0				23. PRIOR AUTHORIZATION NUMBER 1234567		24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE				
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